Report

of the

Examination of

Touchpoint Health Plan, Inc.

Appleton, Wisconsin

As of December 31, 2000

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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December 14, 2001

Honorable Connie L. O'Connell
Commissioner of Insurance
Madison, Wisconsin

Commissioner:

In accordance with your instructions, a compliance examination has been made of the affairs and financial condition of:

TOUCHPOINT HEALTH PLAN, INC.
Appleton, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Touchpoint Health Plan, Inc. (formerly known as United Health of Wisconsin Insurance Company) was conducted in 1998 as of December 31, 1997. The current examination covered the intervening period ending December 31, 2000, and included a review of such 2001 transactions as deemed necessary to complete the examination.

The examination consisted of a review of all major phases of the HMO's operations, and included the following areas:

History
Management and Control
Corporate Records
Conflict of Interest
Fidelity Bonds and Other Insurance
Provider Contracts
Territory and Plan of Operations
Affiliated Companies
Growth of the HMO
Reinsurance
Financial Statements

Accounts and Records
Data Processing

Emphasis was placed on the audit of those areas of the HMO's operations accorded a high priority by the examiner-in-charge when planning the examination. Special attention was given to the action taken by the HMO to satisfy the recommendations and comments made in the previous examination report.

The section of this report titled "Summary of Examination Results " contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comment on the remaining areas of the HMO's operations is contained in the examination work papers.

The HMO is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

II. HISTORY AND PLAN OF OPERATION

Touchpoint Health Plan, Inc., formerly known as United Health of Wisconsin Insurance Company, Inc., (THP or the HMO) can be described as a for-profit stock health maintenance organization insurer organized under ch. 611, Wis. Stat. The company's major line of business is a network model health maintenance organization (HMO) product. An HMO is defined by s. 609.01 (2), Wis. Stat., as ". . . a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that make available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the network model, the HMO provides physicians care services through contracts with more than one group practice. HMOs compete with traditional fee-for-service health care delivery.

The HMO was incorporated February 2, 1988, and commenced business April 1, 1988. Prior to September 29, 1995, Touchpoint was a wholly owned subsidiary of United Investors, Inc. (UII). On September 29, 1995, Aurora Ventures, Inc., purchased a 25% ownership interest in Touchpoint. On September 1, 1997, United Providers, Inc. (UPI) purchased a 15% ownership interest in Touchpoint. During 2001 THP bought back Aurora Ventures interest. As a result, UII and UPI ownership interests increased to 80% and 20%, respectively. UII and UPI are for-profit stock corporation holding companies. UII is 51% owned by ThedaCare Inc, Inc., a not-for-profit organization and 49% owned by other investors. UPI is 89% owned by Bellin Health, a not-for-profit organization and 11% by other investors.

Touchpoint contracts with groups and individual physicians for the provision of primary and specialist care services. Currently, the HMO contracts with 308 primary care physicians and 616 specialists. The HMO requires enrollees to choose a primary care physician (PCP) who serves as a gatekeeper. The PCP must preauthorize all referrals to specialists.

Under the participating provider agreement, the physician agrees to provide medically necessary covered health services to enrollees who have selected the provider for primary care services or who are referred by other participating providers for specialty care. PCPs are compensated at the maximum allowable level or the billed amount, whichever is less.

The maximum allowable level is based upon the unit values established by Relative Value Studies, Inc. Primary Care Physician reimbursement is subject to a 10% to 15% withhold, the disposition of which is ultimately subject to board approval. To assist in the determination of withhold return, the board annually approves a reimbursement plan whereby PCP withhold is returned based upon their success in financially managing a defined patient population. In addition, PCP's are paid additional compensation for achieving certain defined disease management, pharmacy and miscellaneous HEDIS performance measures. Specialty Services Physicians are compensated on a fee-for-service basis subject to maximum funding. Specialty services are subject to a 20% withhold, the disposition of which is determined by the plan. In determining specialty withhold return, the board references and approves the reimbursement plan. Under such a plan, certain specialties are required to manage physician costs for a defined population to a budgeted per member per month (pmpm) cost. Risk withhold due to health care providers was $7,415,934 at December 31, 2000. The agreement provides that in no event shall the provider bill enrollees for covered services that are a patient liability as defined under their benefit plan.

The HMO currently contracts with approximately 76 clinics. The major clinics are listed below:

Appleton Family Health Center
Arturch Clinic
Associated Family Physicians of Berlin & Wautoma, S.C.
Aurora Medical Group, Inc.
Berlin Medical Group
Children's Health
Children's Clinic of Oshkosh, S.C.
CHN Internal Medicine Clinic
Clintonville Family Practice
Family Health Services, S.C.
Family Practice Associates of Oshkosh
Family Practice of Neenah
Family Doctors, S.C.
Fox Valley Internal Medicine
Geen Lake Medical Clinic
Green Lake Family Practice
Internal Medicine Associates of Oshkosh
Internal Medicine Associates of Neenah
Kaukauna Clinic, S.C.
Mc Donald Clinic
Oconto Primary Care
Seymour Family Medicine Clinic
Shawano Clinic, Inc.
Waupaca Family Medicine
Waushara Family Physicians

The contracts include hold-harmless provisions for the protection of policyholders. The contracts have a one-year term and may be terminated by either party upon 90 days' written notice in advance of the expiration date.

The HMO contracts with 22 hospitals to provide inpatient services. Hospitals are predominantly reimbursed based on inpatient per diems, case rates for outpatient procedures and fee schedules for ancillary services. For some of the high volume hospitals, reimbursement is subject to a 15% withhold, the disposition of which is subject to board approval. Similar to the return of physician withhold, a board approved reimbursement plan is used to allocate provider risk and calculate the actual withhold return. The contracts include hold-harmless provisions for the protection of policyholders.

The following is a listing of hospitals in which participating physicians have admitting privileges. Contracting hospitals are denoted with an asterisk (*).

Appleton Medical Center, Appleton, WI*
Bellin Hospital, Green Bay, WI
Berlin Memorial Hospital, Berlin, WI*
Calumet Medical Center, Chilton, WI*
Children's Hospital of WI
Community Memorial, Oconto Falls, WI
Froedtert Memorial Hospital
Holy Family, Manitowoc, WI
Mercy Medical Center of Oshkosh, Inc., Oshkosh, WI*
Meriter (limited service agreement)
New London Family Medical Center, New London, WI*
Oconto Memorial Hospital, Oconto, WI*
Ripon Medical Center, Ripon, WI*
Riverside Medical Center, Waupaca, WI*
Shawano Medical Center, Shawano, WI*
St. Agnes Hospital, Fond du Lac, WI*
St. Mary's Kewaunee Area Memorial Hospital, Kewaunee, WI*
Theda Clark Regional Medical Center, Neenah, WI*
Two Rivers Community, Two Rivers, WI*
University of Wisconsin Hospital & Clinics, Madison, WI*
Waupun Memorial Hospital, Waupun, WI
Wild Rose Community Memorial Hospital, Wild Rose, WI*

Touchpoint is authorized to do business in Brown, Calumet, Door, Fond du Lac, Green Lake, Kewaunee, Marinette, Marquette, Oconto, Outagamie, Shawano, Waupaca, Waushara, and Winnebago counties. The company also has limited product offerings in Dodge, Jefferson, Kenosha, Manitowoc, Menominee, Milwaukee, Ozaukee, Portage, Racine, Rock, Walworth, Washington, and Waukesha counties. The HMO offers a high option comprehensive health care coverage, which may be changed by riders to include deductibles and copayments. The following basic health care coverages are provided:

Hospital services
Emergency room services
Ambulance services
Primary care services
Maternity benefits
Family planning
Specialty care services
Chiropractic services
Physical medicine (physical, speech, and/or occupational therapy)
Cardiac rehabilitation
Vision care
Hearing exams and hearing aids
Durable medical equipment
Prosthesis
Transplants
Dental/TMJ services
Psychological disorders/mental health & chemical dependency/AODA (alcohol and other drug addictions)
Skilled nursing care facility
Home health care services
Hospice care
Diabetes services
Stay healthy benefit
Physician services

Inpatient mental health and AODA coverage is limited to 30 inpatient days. Transitional mental health and AODA coverage is limited to 20 days. Outpatient mental health and AODA coverage is limited to 25 visits. Emergency room charges are 90-100% of charges after a $25-$100 copayment. The copayment is waived upon admission into a hospital. Skilled nursing care is limited to 30 days per post hospital confinement and home health care is limited to 40 visits per calendar year. Enrollees are required to choose a primary care provider from a list of participating physicians. Plan coverage is contingent on non-emergency services being

provided by participating providers and hospitals or on the referral of participating physicians. The HMO also has copayment plans in which inpatient services have a $100 per day copayment subject to maximums of $500/single and $1,000 /family contract; and office visits have a $10/15/20 copayment per visit. In addition, deductible plans are offered in which inpatient and outpatient services and durable medical equipment have deductibles ranging from $100 to $500 for individual and $200 to $1,000 for family per contract year, and 100% coverage thereafter. Office visits under the deductible plan are subject to a $10/15/20 copayment per visit. There are $1 million/$2 million maximums on the HMO plans.

The HMO, with Touchpoint Insurance Company, Inc., offers point-of-service (POS) products under joint contracts with several liability. The HMO is liable for services provided by participating providers, services from non-participating providers with an authorized referral, and emergency services. Touchpoint Insuance Company, Inc. is liable for non-emergency services to non-participating providers without referral. Coverage for in-plan service is similar to comprehensive HMO benefits described in the previous paragraph. Out-of-plan benefits allow the enrollee to “self-refer” to out-of-plan (nonparticipating) providers. Out-of-plan benefits have deductibles of $200 to $1,000 per individual and $400 to $2,000 per family; and coinsurance requirements of 10% or 20% for in-plan benefits and 20% and 40% for out-of-plan benefits. There is a calendar maximum of $1 million and a $2 million lifetime maximum on out-of-plan services. Coverage for routine physical examinations, well-baby care, immunizations, and routine eye and hearing exams is not provided as an out-of-plan benefit.

Touchpoint currently markets to groups only. The HMO uses internal marketing staff and independent agents for new and renewal business. The sales staff receives salaries and applicable bonuses as compensation; the service staff receives straight salaries. Independent agents receive commissions on a graduated scale. For new business, agent commissions start at 6% for the first $5,000 of annual premium and graduate to 0.5% for annual premium above $200,000. For renewal business, agents’ commissions start at 12% for the first $5,000 of annual premium and graduate to 0.5% for annual premium above $200,000. The company has a

marketing and administrative agreement with Humana. Under the contract, Humana becomes a marketing and administrative agent for Touchpoint's products sold to employer groups of 2 to 99 employees. For those services, Humana is paid 5.5% of premium, 2% for profit and 3.5% to cover their administrative overhead.

The HMO uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted to reflect the age, sex, occupation, and coverage characteristics for new groups. Experience is reviewed for renewal groups and, based on the review, a recommendation is made regarding adjusting the rate or canceling the group. The base rate is adjusted quarterly for inflation and other trending factors.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of nineteen members. Directors are elected annually to serve a three-year term. Officers are elected by the board of directors. Members of the HMO's board of directors may also be members of other boards of directors in the holding HMO group. The board members currently receive no compensation for serving on the board.

At the time of the examination, the board of directors consisted of the following persons:

Name and Residence	Principal Occupation	Term Expires
Dave Albrecht Green Bay, Wisconsin	Executive Vice President/CFO Bellin Hospital	2002
Scott Anderson, MD Green Bay, Wisconsin	Physician, Family Doctors of Howard	2002
Curtis Baltz, MD Neenah, Wisconsin	Physician, Internal Medicine Theda Clark Hospital	2002
Clark Boren, MD Appleton, Wisconsin	Physician, Fox Valley Surgical Associates	2003
Susan Buettner Milwaukee, Wisconsin	Director, Aurora Health Care	2001
Janine Buffo, MD Appleton, Wisconsin	Physician, ThedaCare Physicians	2001
Mark Chelsky, MD Appleton, Wisconsin	Physician, Valley Urologic Associates	2002
Michael Duffy, MD Oshkosh, Wisconsin	Physician, Oshkosh Internal Medicine	2001
William Guenther, MD Appleton, Wisconsin	Physician, Fox Valley Hematology & Oncology	2001
Rance Hafner, MD Green Bay, Wisconsin	Physician, Family Practice Associates	2002
Jonathan Hagen, MD Appleton, Wisconsin	Physician, Primary Care Associates	2003
Brad Hahn Sheboygan, Wisconsin	Vice President, Finance Aurora Health Care	2002

Board of Directors (cont.)

Name and Residence	Principal Occupation	Term Expires
Thomas Koehler, MD Green Bay, Wisconsin	Physician, Deckner Clinic	2001
Kathy Ledvina Milwaukee, Wisconsin	Director-Managed Care Aurora Health Care	2002
Douglas Mielke, MD Neenah, Wisconsin	Physician, Cardiology Associates	2001
Warren Parsons Appleton, Wisconsin	President, Oscar Boldt Construction	2003
Thomas Prosser Neenah	Senior Vice President Menasha Corporation	2002
Steve Van Dyke Green Bay, Wisconsin	President, Foth & Van Dyke	2001
Frank Wiesner Neenah, Wisconsin	Chairman of the Board Touchpoint Health Plan	2002

Officers of the Company

The officers elected by the board of directors and serving at the time of this examination are as follows:

Name	Office	2000 Salary
Jay Fulkerson	President	$312,415*
Curtis Baltz, MD	Secretary	0**
Jeffrey Hacker	Chief Financial Officer	119,000*
Dean Gruner, MD	Other Officer	$70,000***

*Employees of ThedaCare. Salary includes compensation for duties performed for Touchpoint and other affiliates.
**No compensation received for being a board member.
***Represents a portion of salary allocated to Touchpoint.

Committees of the Board

The HMO's bylaws allow for the formation of certain committees by the board of directors. The committees at the time of the examination are listed below:

Executive Committee
Frank Wiesner, Chair
William Guenther, MD
Curtis Baltz, MD
Warren Parsons
Jay Fulkerson
Dean Gruner, MD

Nominating Committee
Frank Wiesner, Chair
Mark Chelsky, MD
Curtis Baltz, MD
Warren Parsons
William Guenther, MD
Douglas Mielke, MD

Finance Committee
Warren Parsons, Chair
Dave Albrecht
Curtis Baltz, MD
Clark Born, MD
Mark Chelsky, MD
John Lindstrom, MD
Terry Murray
Hassan Shahbandar, MD
Frank Wiesner
Rick Born
Jay Fulkerson
Dean Gruner, MD
Jeff Hacker
Pat Hawley

The HMO has no employees. Necessary staff is provided through a management agreement with ThedaCare, Inc. Under the agreement, effective March 1, 1995, ThedaCare agrees to negotiate employer, provider, subscriber, and other contracts; advises the board; maintains accounting and financial records; recruits marketing, utilization review, and claims processing personnel; provides or contracts for claims processing, and MIS. ThedaCare receives a monthly fee based on allocation of the prior twelve months costs as compensation for services rendered. The term of the agreement is three years with automatic renewal for additonal three-year periods. The HMO may terminate the agreement upon thirty days' written notice if default of standards of performance continues 60 days after notice of such default.

Financial Requirements

The financial requirements for an HMO under s. Ins 3.50, Wis. Adm. Code, are as follows:

		Amount Required
1.	Minimum capital or permanent surplus	Either: $750,000, if organized on or after July 1, 1989 or $200,000, if organized prior to July 1, 1989
2.	Compulsory surplus	The greater of $750,000 or: If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous 12 months; If the percentage of covered liabilities to total liabilities is at least 90%, 3% of the premium earned in the previous 12 months
3.	Security surplus	The greater of: 140% of compulsory surplus reduced by 1% of compulsory surplus for each $33 million of additional premiums earned in excess of $10 million or 110% of compulsory surplus
4.	Operating funds	Funds sufficient to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus

Covered liabilities are those due to providers who are subject to statutory hold-harmless provisions.

In addition, there is a special deposit requirement equal to the lesser of the following:

1. An amount necessary to maintain a deposit equaling 1% of premium written in this state in the preceding calendar year;

2. One-third of 1% of premium written in this state in the preceding calendar year.

The HMO has satisfied this requirement for 2000 with a deposit of $1.9 million with the State Treasurer.

Insolvency Protection for Policyholders

Under s. Ins 3.50, Wis. Adm. Code, HMOs are required to provide continuation of coverage for its enrollees. These requirements are the following:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and

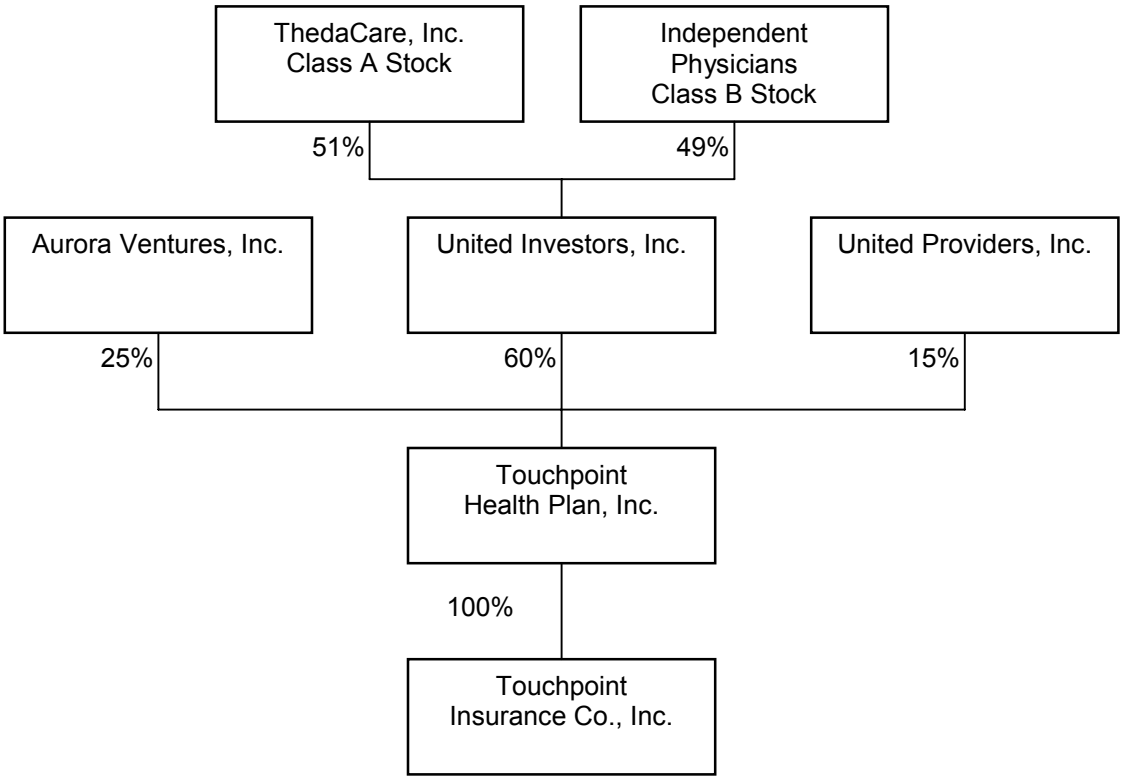
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

The HMO has met this requirement through its reinsurance contract, as discussed in the Reinsurance section of this report.

IV. AFFILIATED COMPANIES

The HMO is a member of a holding company system. Its ultimate parent is United Investors, Inc. The organizational chart below depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the HMO follows the organizational chart.

Holding Company Chart
As of December 31, 2000



United Investors, Inc.

United Investors, Inc.is a holding company and is 51% owned by ThedaCare, Inc. and 49% owned by other investors. UII writes group health insurance through its majority-owned subsidiary, Touchpoint Health Plan, Inc. As of December 31, 2000, UII's audited consolidated financial statements reported assets of $62,980,000, liabilities of $44,939,000 shareholders equity of $12,093,000 and minority interest of $5,948,000. Operations for 2000 produced net income of $698,000.

ThedaCare, Inc.

ThedaCare Inc. is a nonprofit organization incorporated in 1985 and is exempt from income taxes under section 501(c)(3) of the Internal Revenue Code. ThedaCare is a health provider system owning three hospitals, a number of primary care clinics, a nursing home, and other ancillary health care providers. The provider is a 51% owner of United Investors, Inc. As of December 31, 2000, ThedaCare's audited consolidated financial statements reported assets of $354,562,000, liabilities of $132,259,000 and net assets of $222,203,000. Operations for 2000 produced net income of $31,841,000.

Touchpoint Insurance Company

Touchpoint Insurance Company (TIC) is a wholly-owned subsidiary of Touchpoint Health Plan, Inc. and is a stock insurance corporation organized under Chapter 611 of Wisconsin Statutes. TIC was granted a certificate of authority on December 9, 1998 and commenced business on January 1, 1999. As of December 31, 2000, TIC's audited financial statements reported assets of $3,873,127, liabilities of 1,516,401, and surplus of $2,356,726. Operations for 2000 produced a net loss of $(95,301).

V. REINSURANCE AND CORPORATE INSURANCE

The HMO has reinsurance coverage under an affiliated ceding contract outlined below:

Reinsurer:	Touchpoint Insurance Company
Type:	Assumption reinsurance for indemnity coverage for point of service products
Effective date:	January 1, 1999
Retention:	
Coverage:	90% of THP's gross earned premium on point of service business
Premium:	14% of gross earned premium for large groups 3% of gross earned premium for small groups
Termination:	Will remain in effect until terminated.

The HMO has reinsurance coverage under the nonaffiliated contract outlined below:

Reinsurer:	ING Re Underwriters, Inc.
Type:	Specific Excess of Loss Reinsurance
Effective date:	October 1, 2000
Retention:	$150,000 per commercial and point of service per member per agreement year; $100,000 per Medicaid and Medicare per member per agreement year
Coverage:	90% of eligible inpatient hospital services and eligible outpatient health services if performed under a per diem or fixed fee contract 80% of eligible inpatient hospital services and eligible outpatient health services if not performed under a per diem or fixed fee contract 90% of eligible inpatient hospital services and eligible outpatient health services performed at University of Wisconsin Hospital 90% of eligible inpatient hospital services and eligible outpatient health services related to organ and bone marrow transplants if performed under a ING Re-approved transplant contract or network 50% of eligible inpatient hospital services and eligible outpatient health services related to organ and bone marrow transplants if performed under any other transplant contract 80% of eligible out of area emergency hospital services

Premium:	$.38 per member per month for commercial members and point of service members $.74 per member per month for Medicare members $.58 per member per month for Medicaid members
Termination:	Reinsurer to give THP 90 days notice

The reinsurance policy has an endorsement containing the following insolvency provisions:

1. ING Re will continue plan benefits for members who are confined in an acute-care hospital on the date of insolvency until their discharge.

2. ING Re will continue plan benefits for any member insured plan until the end of the contract period for which premiums have been paid to plan by that member or on his behalf.

3. ING Re will make available to all members for a period of thirty-one days, without evidence of insurability, a replacement coverage of the same benefit schedule and rates as then being offered by ING Re to other prospective insureds within the state.

In addition, the HMO is provided with corporate insurance coverage under the contracts listed below:

Type of Coverage	Policy Limits
Directors' and officers' liability	$10,000,000
Professional liability	$10,000,000

The above coverages were obtained through the Chubb Group Insurane which is licensed in Wisconsin.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the HMO as reported in the December 31, 2000, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the HMO for the period under examination. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Net Worth per Examination."

Touchpoint Health Plan, Inc.
Assets
As of December 31, 2000

Current Assets:		
Cash	$14,970,120	
Premiums receivable--net	5,941,707	
Investment income receivable	176,207	
Health care receivables	1,351,581	
Amounts due from affiliates	299,017	
Reinsurance recoverable on paid losses	70,164	
Prepaid expenses	521,333	
Deferred and prepaid income tax	1,031,159	
Refundable income tax	71,246	
Total current assets		$24,432,534
Other Assets:		
Bonds	8,589,934	
Common stocks	12,434,131	
Miscellaneous investments	62,500	
Total other assets		21,086,565
Property and Equipment—Net:		
Land, buildings, and improvements	6,617,706	
Furniture and equipment	1,303,775	
EDP equipment	1,315,342	
Administration	7,833	
Total property and equipment		9,244,656
Total Assets		$54,763,755

Touchpoint Health Plan, Inc.
Liabilities and Net Worth
As of December 31, 2000

Current Liabilities:		
Accounts payable	$677,252	
Claims payable (reported and unreported)	32,722,453	
Unearned premiums	4,008,829	
Amounts due to affiliates	892,328	
Commissions	99,437	
Accrued salaries and benefits	1,005,179	
Accrued assessments	34,336	
Abandoned property	44,545	
Deferred income taxes	633,048	
Accrued sales taxes	397	
State income taxes payable	25	
Total current liabilities		40,167,829
Other Liabilities:		
Accrued loss adjustment	404,000	
Total other liabilities		404,000
Total liabilities		40,571,829
Net Worth:		
Common stock	849,400	
Paid-in surplus	6,659,634	
Retained earnings/fund balance	6,682,892	
Total net worth		14,191,926
Total Liabilities and Net Worth		$54,763,755

Touchpoint Health Plan, Inc.
Statement of Revenue and Expenses
For the Year 2000

Revenues		
Premium	$223,122,488	
Net investment income	1,617,723	
PPO fees	1,397,452	
Administrative service contracts	235,319	
Other revenue	(37,120)	
Total revenue		226,335,862
Medical and Hospital Expenses		
Physician services	96,028,448	
Other professional services	62,799,580	
Inpatient	41,580,125	
Incentive pool and withhold adjustments	(2,733,330)	
Pharmacy	27,448,760	
Risk sharing income	(3,147,031)	
Subtotal	221,976,552	
Less:		
Net reinsurance recoveries incurred	277,206	
Copayments	7,757,762	
COB and subrogation	11,109,236	
Subtotal	19,144,204	
Total medical and hospital		202,832,348
Administrative Expenses		
Administrative expenses		20,861,311
Total expenses		223,693,659
Income/(loss)		2,642,203
Extraordinary item		
Provision for federal income taxes		967,067
Net Income/(Loss)		$ 1,675,136

Touchpoint Health Plan, Inc.
Statement of Net Worth
As of December 31, 2000

Net worth, beginning of year	$14,274,033
Net income (loss)	1,675,136
Decrease (increase) in nonadmitted assets	461,170
Unrealized capital gains and losses	(2,218,413)
Net worth, end of year	$14,191,926

Touchpoint Health Plan, Inc.
Statement of Cash Flows (Indirect Method)
As of December 31, 2000

Cash Flows From Operating Activities		
Net income (loss)		$1,675,136
Adjustments to reconcile net income (loss) to net cash provided (used) by operating activities:		
Depreciation and amortization		819,750
Change in operating assets and liabilities:		
(Increase)/Decrease in operating assets:		
Premium receivable		(4,009,279)
Due from affiliates		(299,017)
Health care receivable		(491,839)
Write-ins for (increase)/decrease in operating assets:		
Prepaid expenses		120,751
Refundable or Deferred Income Tax		1,075,323
Change in non-admitted assets		461,170
Reinsurance recoveries		65,718
Increase/(Decrease) in operating liabilities:		
Medical claims payable		12,421,475
Due to affiliates		487,590
Unearned premiums		2,337,686
Accounts payable		(402,953)
Write-ins for (increase)/decrease in operating liabilities:		
Accrued loss adjustment		48,000
Accrued salaries and benefits		176,358
Other accrued expenses		(1,131,473)
Net cash provided from (used by) operating activities		13,354,396
Cash Flows From Investing Activities		
Receipts from investments	(29,085)	
Payments for investments	25,959	
Payments for property, plant, and equipment	(1,001,155)	
Net cash provided from (used by) investing activities		(1,004,281)
Net increase (decrease) in cash and cash equivalents		12,350,115
Cash and cash equivalents at beginning of year		2,620,005
Cash and Cash Equivalents at End of Year		14,970,120

Growth of Touchpoint Health Plan, Inc.

Year	Assets	Liabilities	Net Worth	Premium Earned	Medical Expenses Incurred	Net Income
2000	$54,763,755	$40,571,829	$14,191,926	$223,122,488	$202,832,348	$1,675,136
1999	40,909,179	26,635,146	14,274,033	191,038,828	178,152,378	(1,917,958)
1998	38,852,201	25,972,623	12,879,578	160,094,123	142,866,478	1,127,478

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2000	140,680	240.58	3.28
1999	137,604	234.40	3.34
1998	119,690	253.40	3.24

Per Member Per Month Information

	2000	1999	Percentage Change
Premiums:			
Commercial	$134.42	$119.27	12.70%
Medicaid	118.89	112.24	5.92%
Expenses:			
Physicians services	57.30	55.98	2.35
Other professional	37.47	37.36	.30
Inpatient	24.80	22.89	8.34
Incentive pool adjustment	(1.63)	(7.98)	(79.57)
Other medical	14.50	13.57	6.85
Net reinsurance recoveries incurred	(0.17)	(1.14)	(85.55)
Copayments	(4.63)	(4.37)	5.95
COB and subrogation	(6.63)	(5.50)	20.54
Total Medical	121.02	110.81	9.23
Administrative Expense	12.45	11.89	4.71
Total Expenses	$133.46	$122.70	8.79

Reconciliation of Net Worth per Examination

As a result of this examination, one reclassification was made and no adjustments were made to surplus.

Examination Reclassifications

	Debit	Credit
Premium Receivable	$	$150,100
Healthcare Receivable	150,100	
Total reclassifications	$150,100	$150,100

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were ten specific comments and recommendations in the previous examination report. Comments and recommendations contained in the last examination report and actions taken by the HMO are as follows:

1. Cash—It is recommended that the company file unclaimed property reports as required by ch. 177, Wis. Stats.

   Action—Compliance.

2. Investments—It is again recommended that the company amend its safekeeping agreement to include provisions required by the NAIC Examiners Handbook.

   Action—Partial compliance.

3. Management and Control—It is recommended that either the board of directors or a subordinate committee pass upon the purchase or sale of all investments of the HMO, and that the minutes of the proceeding reflect the same.

   Action—Compliance.

4. Financial Reporting—It is recommended that the HMO file amended 1997 Reports on Executive Compensation (Form OCI 22-060) for proper disclosure of officers and employees compensation. Also, it is recommended that the HMO report on executive compensation in the future as required by s. 611.63 (4), Wis. Stat.

   Action—Non compliance.

5. Financial Reporting—It is recommended that the HMO disclose all of its officers and directors in the annual statement in accordance with the NAIC HMO Annual Statement Instructions.

   Action—Compliance.

5. Financial Reporting—It is again recommended that the company complete the annual statement in accordance with the NAIC HMO Annual Statement Instructions.

   Action—Compliance.

6. Corporate Records—It is again recommended that the HMO file biographical information for its officers and directors with OCI within 15 days after their election of appointment as required by s. 611.57, Wis. Stat., and s. Ins. 6.54, Wis. Adm. Code.

   Action—Compliance.

7. Corporate Records—It is recommended that conflict of interest statements be completed annually by all directors, officers, and senior management employees.

   Action—Compliance.

8. Corporate Records—It is recommended that the minutes of the board of directors meetings reflect election of directors and appointment of officers in conformity with the HMO's bylaws.

   Action—Compliance.

9. Corporate Records—It is recommended that the company change its computer access security to lock out User IDs after a password has been incorrectly entered three times.

   Action—Compliance.

Summary of Current Examination Results

Bonds

A review of the custodial agreement revealed that a clause relating to prompt replacement of lost securities was not included in the indemnification language. According to the NAIC Examiners' Handbook, custodial agreements need provisions similar to the following: "in the event of a loss of securities for which the bank or trust company is obligated to indemnify the insurance company, the securities shall be promptly replaced or the value of the securities and the value of any loss of rights or privileges resulting from said loss of securities shall be promptly replaced." It is recommended that the company add an indemnification clause regarding prompt replacement of securities to its custodian agreement in accordance with the NAIC Examiners' Handbook.

The custodial agreement was in the name of United Health of Wisconsin. The company's name was changed to Touchpoint Health Plan, Inc. in 1999. The company should update its custodial agreement to reflect the proper name of the insurer when it is amended per the above recommendation.

Premium Receivable

The company has issued administrative service only or ASO (uninsured) contracts to employers that self-fund their health benefit plans. The examination noted that the HMO included amounts due from these employers as Premium Receivable. The term "premium" relates to insurance contracts, therefore the amounts due from ASO arrangements should be included in health care receivables or amounts receivable relating to uninsured accident and health plans in future statements. The examination reclassified $150,100 from Premium Receivable to Health Care Receivables. Enrollment for the ASO groups should not be included in the enrollment schedule either, it should be disclosed in the notes to the financial statements. It is recommended that the company report uninsured business separately from insured business as required by the NAIC Accounting Practices and Procedures Manual.

Underwriting

As discussed previously, the company issues a point-of-service product jointly with its affiliate. Section 631.41, Wis.Stat. allows two or more insurers to together issue a policy. If the contract has several liability, the heading of the policy must conspicuously so state and the policy must conspicuously state the proportion or amount of premium to be paid to each insurer and the type and the proportion or amount of liability each insurer agrees to assume. The group master policies lacked information about the exact percentage of premium each insurer is to be paid. The policy states that Touchpoint Health Plan receives 86%-90% of the premium. It is recommended that the company state the proportion or amount of premium to be paid to each insurer on its joint policies in accordance with s. 631.41, Wis. Adm. Stats.

Financial Reporting

The executive compensation reports submitted to the Commissioner's Office as a supplemental filing with the annual statement were incomplete. It is again recommended that the company submit executive compensation reports with its annual statements in accordance with s. 611.53 (4), Wis. Stats.

EDP Environment

A thorough review was conducted of the electronic systems environment. Overall, it appears that the company has implemented numerous controls for the security of its information. However, enhancements were suggested by the examiners to improve the safeguarding of these assets. A report was given to the company detailing all of the findings. Some of the deficiencies found consisted of the following:

- Blank check stock is taken out of locked storage during the day and then locked up at night. Check stock should only be removed from storage when needed.
- Doors to the server and wiring rooms are not always locked. Access to computer hardware and supporting devices should be restricted.
- Backups of servers are done nightly, but the tapes remain on-site for a week. To avoid the loss of a week's information, tapes should be removed from the premises on a daily basis.

- The disaster recovery plan lacked details about identifying communication trees, procedures, and certain assumptions. Details should be added to the plan for clarity purposes.

It is recommended that the company review the controls in place and implement procedures to enhance the safeguards of its information.

Compulsory Surplus Requirement

As noted in the section of this report captioned "Financial Requirements," HMOs are required to maintain minimum compulsory surplus. The HMO's calculation as of December 31, 2000, is as follows:

Assets	$54,763,755	
Less:		
Special deposit	1,925,158	
Liabilities	40,500,583	
Security surplus of insurance company subsidiary	2,800,000	
Total		$9,538,014
Net premium earned	223,122,488	
Compulsory factor	3%	
Compulsory surplus		6,693,675
Compulsory Excess		$2,844,339

IX. CONCLUSION

Since the last examination as of December 31, 1997, Touchpoint Health Plan, Inc. experienced significant growth in assets, net worth, and premium. Assets increased by 55%, liabilities increased by 34%, net worth increased by 38% and premium increased 79%. Enrollment increased from 97,576 members in 1997 to 140,680 members in 2000 which represents a 44% increase.

On January 1, 1999, THP established a wholly-owned subsidiary, Touchpoint Insurance Company. The subsidiary was formed to insure the out-of-network benefits of the HMO's point of service business through a jointly issued policy.

The current examination made five recommendations, one of which was repeated from the previous examination report. There were no adjustments made to the company's reported net worth, however one reclassification was made related to financial reporting for uninsured plans.

X. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 28 Investments—It is recommended that the company add an indemnification clause regarding prompt replacement of securities to its custodian agreement in accordance with the NAIC Examiners' Handbook.

2. Page 28 Premium Recievable—It is recommended that the company report uninsured business separately from insured business as required by the NAIC Accounting Practices and Procedures Manual.

3. Page 29 Accounts and records—It is recommended that the company state the proportion or amount of premium to be paid to each insurer on its joint policies in accordance with s. 631.41, Wis. Adm. Stats.

4. Page 29 Accounts and Records—It is again recommended that the company submit executive compensation reports with its annual statements in accordance with s. 611.53 (4), Wis. Stats.

5. Page 30 EDP Environment—It is recommended that the company review the controls in place and implement procedures to enhance the safeguards of its information.

XI. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employees of the HMO is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, State of Wisconsin, participated in the examination:

Name	Title
Sonja Dedrick	Insurance Financial Examiner
Rebecca Easland	Insurance Financial Examiner

Respectfully submitted,

Theresa McClintock
Examiner-in-Charge